can public can only hope that close attention will be given to what happened at HPAAN when "297 leaders among the Nation's health interests," as the report characterizes the survey respondents, wrote the RMP epitaph.

E. R. W. FOX, MD
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REFERENCE

1. Policy Lessons Learned From the Regional Medical Program (RMP) Experience—A Preliminary Report. Boise, Idaho, Health Policy Analysis and Accountability Network, Inc., 1977

Drug Abuse and Detoxification

TO THE EDITOR: Thank you for the four pages dedicated to substance abuse in the July 1977 issue of WESTERN JOURNAL (Notes on Alcoholism and Drug Abuse).

If I am included in your "consensus of practicing physicians," I must protest. The statements were fine as far as they went, but in an effort to make the statements simple or because of publishing restrictions, you have left out important facts that need to be available to every physician confronted with these problems.

First, in relation to phencyclidine (PCP): It is seldom the sole drug of abuse. Often the patient has a long previous history of glue sniffing or amphetamine abuse, up to 10 grams a day taken intravenously for months, or barbiturate abuse of 2 grams per day or months of chronic alcohol consumption to drunkenness. Each of these abuses may bequeath important medical problems to the PCP user. More important a large number of the heroin addicts I treat have abused PCP in the past —almost 1,000 out of 3,500 different heroin addicts I have studied. More important still, many PCP addicts are already abusing heroin and cocaine when they first come to the attention of a physician.

In regard to the use of propoxyphene napsylate (PN) (Darvon-N®) in detoxing, I agree entirely with the article as far as it goes. However, based on an experience with more than 6,000 separate detoxifications, a third on methadone, two thirds on PN, I would warn that many heroin addicts should not be detoxed as outlined.

Heroin addicts can be easily grouped into "junkies" who need routine detox (about half of those seen); addicts so depressed, even suicidal, that the depression must be treated before they can safely be detoxed; addicts so gripped by the acute anxiety syndrome that they need massive reassurance and placebos so that routine treatment would be a disservice; addicts who are out to manipulate the physician for the sake of manipulation. These "Baron Munchausens" are well known in the medical literature but only recently have we been able to appreciate how devastating they are to detox programs.[1] Individual physicians willing to use any detox schedule on a heroin addict must be prepared to take into account the special considerations needed for preventing suicide, purposeful nonsuicidal overdose or fraud.

Physicians who are not willing to treat substance abusers need a good incidence figure to judge for themselves how many of their patients are occult abusers or disguised abusers with multiple habits. For example, most alcoholics who also abuse heroin or PCP cannot get treatment from programs or from private physicians unless they hide the use of one or more of their other drugs. Most alcoholics who are suicidal cannot get treatment from alcoholism programs and most heroin addicts who are suicidal cannot get treatment from heroin programs unless they hide their suicidal tendencies—all this at a time when they very much need to talk about their depressions. In Alameda County, California, about one in 20 adults who might go as patients to practicing physicians have some problems with heroin, three of 20 adults have enough problems with alcohol to be of concern to their physicians (Hayward O: Unpublished data).

We do a disservice to private physicians unless we emphasize that most substance abusers have complex problems and that more than a third of them are seriously depressed.

Further, I would quarrel with the amount of PN suggested by Rossiter. For six months I have been using the following successfully in ambulatory addicts: PN, 600 mg per day for seven days and diazepam (Valium®) 30 mg per day and chloralhydrate, 1 gram per day with a vigorous hydrotherapy schedule with fluid and potassium replacement. They must understand that for two or three days they will feel as ill as with the grippe. In these circumstances 80 percent of heroin addicts have a good detox with most taking the next step toward rehabilitation. Most of our failures were among those with severe acute anxiety, often with minor addiction.

A minor point in Dr. Hayes' article—it is not enough for the physician or his nurse to stand at the bathroom door and stare at the patient's back as the urine is passed. Addicts are skilled in unbelievable subterfuge by years of urine testing in

the criminal justice system. "Personal supervision of the patient" means the urine is watched going from urethra into the bottle and the bottle, still warm, is handed to the watcher.

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REFERENCE

1. Asher R: Munchausen's syndrome. Lancet 1:339-341, Feb 10, 1951

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Dr. Rossiter Responds

TO THE EDITOR: The letter from Dr. Hayward deserves a response. I refer to his comments relative to the use of propoxyphene-napsylate (PN) in the use of heroin detoxification.

There is no disagreement with the dose range suggested by Dr. Hayward for PN in detoxification of heroin addicts and as it is combined with other medications. The article in the WESTERN JOURNAL stated that "many physicians are at present prescribing the drug at high doses [higher than those specified in the package insert]—and at low doses in combination with target symptom medications." The dosage specified in the article at 800 to 1,200 mg per day and tapered to zero in 5 to 21 days is the dose range being used in those experimental projects approved by the California Research Advisory Panel. The article presents guidelines, but in a perfunctory manner. I suggest that Dr. Hayward and others interested in further exploration of this subject should read the proceedings of a symposium on the investigational use of PN in the treatment of narcotic dependency.[1]

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REFERENCE

1. Meyers FH, Dow GJ (Eds): The Investigational Use of Propoxyphene in the Treatment of Narcotic Dependency—Proceedings of a Symposium sponsored by the Research Advisory Panel of the State of California, December 5, 1975, San Francisco. (Copies available from Research Advisory Panel of the State of California, 6000 State Building, San Francisco, CA 94102.)

Concerning Libraries in Smaller Hospitals

TO THE EDITOR: Hospitals of all sizes need library services to provide up-to-date information for physicians, to support continuing education programs, and to meet the standards of the Joint Commission on Accreditation of Hospitals and the applicable state codes (in California, the California Administrative Code[1]).

A small community hospital neither needs nor can afford the facilities and services of a large university affiliated research oriented metropolitan hospital.[2] Nevertheless, the common practice of designating as a library a conference room or physicians' lounge with bookshelves crammed with outdated medical textbooks and old journals, together with a few purchases of *Current Therapy,* is clearly inadequate. The essence of a useful library is the organization of the material to make it accessible, and the provision for access to information that is not in the library but is available elsewhere. This can be provided through the services of a professional medical librarian.

Various methods for providing such professional library services to small hospitals have been reported.[3-5] In contrast with these programs, which are affiliated with institutions in large medical centers, three small acute-care hospitals in the vicinity of the San Francisco Bay area are providing quality medical library services at little cost by contracting with an independent consultant who works a few hours a week at each hospital. Doctors' Hospital of Pinole (137 beds), Vallejo General Hospital (99 beds) and Intercommunity Hospital in Fairfield (80 beds) are small, acute-care general hospitals about 20 miles apart and 30 to 50 miles from San Francisco. Each of the hospitals has set aside a room to serve as a library in accord with Title 22 of the State of California Administrative Code, but the "libraries" were much as described above.

Thus, the librarian's first task was to identify the books that clearly should be retained and make recommendations to the library committee concerning the disposition of the balance. The retained books were catalogued and classified, and recommendations were made to the library committee for first and second priority purchases to assure an adequate core library. In addition, special subject sections were developed to support the clinical departments of each hospital. For example, Doctors Hospital of Pinole has a total body scanner and no obstetrics department; Vallejo General Hospital has strong respiratory and physical therapy units; Intercommunity Hospital has active obstetric and pediatric departments. The collections at each hospital reflect these differences.

The essential minimum service provided by the consulting medical librarian is the organization and maintenance of the library so that current information is available and can be found readily. The most valuable contribution which the librarian can make to patient care is the provision of reference services to the doctors.